MONTEFIORE MEDICAL CENTER The University Hospital for the ALBERT EINSTEIN COLLEGE OF MEDICINE

Department of Obstetrics & Gynecology and Women's Health Division of Reproductive Genetics

Patient History (Social, Family and Medical)

Patient Name			Social Security #		
			Zip Code		
Phone Number	(Home)		(Work)		
Date of Birth _	//	Age Occ	upation		
Race/Ethnicity	\square Caucasian	\square African American \square Hi	spanic \square Asian \square Other		
Religious Affiliat	Religious Affiliation Blood Type				
Last Menstrual F	Period/_	/ Date of Sonogro	m/ Weeks		
Name of Baby's	s Father				
			upation		
Race/Ethnicity		☐ African American ☐ His	spanic 🗆 Asian 🗆 Other		
		Review of Syste	ms		
Please answer	YES ior NO if vol	ı have any of the following r			
YES	NO	ILLNESS	•		
П	П	Diabetes			
		High Blood Pressu	re		
	☐ Heart Disease				
	Autoimmune Diseases such as Arthritis or Lupus				
	☐ Kidney Diseases				
	☐ Urinary Tract Infection				
	Neurologic Disease such as Seizures or Epilepsy				
	Hepatitis, Yellow Jaundice, or other Liver Diseases				
	Bowel Problems				
	☐ Phelbitis or other varicosities (swelling of blood vessels) ☐ Recurrent Pregnancy Loss				
	☐ Infertility (difficulty in getting pregnant)				
\Box	Thyroid Problems				
	☐ Muscle Weakness				
	Skin Problems				
	☐ Hearing or Vision Problems				
	Allergies				
	Anemia, History of Blood Transfusion				
	☐ ☐ Rh Incompatibility (Rh negative)				
	☐ Lung disease such as Asthma☐ Operations and Hospitalizations				
	Trauma or Domestic Violence				
	Cancer				
	_	If yes, where?			

		Pas	t Pregnancies
Please list in chronological order, including living children (names, sex, dates of birth, birth weight, and present health status) and miscarriages, abortions, stillbirths, premature births and early infant deaths.			
		N	Medications
Please list all me	edications, pre	escriptions and	over-the-counter drugs taken during this pregnancy
MEDICATIONS		DOSAGE	REASON FOR MEDICATION
		C	rant Drawnanay
			rent Pregnancy
Please answer Y	ES or NO to ti	he following qu	estions regarding this pregnancy
Smoking	☐ Yes	□ No	# of Cigarettes per day Years
Alcohol	☐ Yes	□ No	
Drug Use	☐ Yes	□ No	If Yes, name of drug(s)
Have you or the	baby's fathe	er had X-rays in	the past six months?
If Yes, ple	ease explain		
Does the baby's	s father have	any medical p	roblems?
If Yes, ple	ease explain		
If the results indi	cate a fetal c	abnormality, wo	ould you consider an abortion?
Completed By	: 🗆	Patient	\square Office Staff \square Physician/Medical Provider
Signature of Po			
Date Reviewe Physician Sign			
i riyacidir algir	uiuie		
Comments			
_			

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Cystic Fibrosis Carrier Screening

Cystic Fibrosis (CF) is the most common severe and usually fatal inherited disease in Caucasian families. CF clogs the lungs and pancreas with thick mucus and causes severe breathing and digestive problems. CF occurs in about 1 in 3,300 births in the United States.

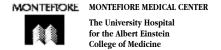
To have a child with CF, both parents must be carriers of a change in the CF gene. The carrier rate and the ability to detect a carrier are different in various ethnic groups, as shown below:

Race or Ethnicity	# of Babies Born	Chance of Being a Carrier	Carrier Detection Rate
Northern European	1/2,500	1/25 - 1/29	85 - 90%
Southern European	1/2,500	1/25 - 1/29	70%
Ashkenazi Jewish	1/2,800	1/26 - 1/29	97%
Hispanic	1/8,100	1/46	57%
African American	1/14,500	1/60 - 1/65	72%
Asian	1/32,000	1/90	30%

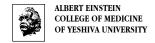
Because we cannot detect all carriers, a negative screen does not guarantee an unaffected pregnancy. It is your decision to have or not to have this blood test.

Please check below:

	Yes, I would like to have CF screening				
	No, I am not interested in CF screening				
Print Name:		_			
Signature: _		_ Date _	/	/	



DEPARTMENT OF OBSTETRICS &
GYNECOLOGY AND WOMEN'S HEALTH
DIVISION OF REPRODUCTIVE GENETICS



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TO ALL PATIENTS:

The Department of Obsterics & Gynecology and Women's Health, Division of Reproductive Genetics is committed to protecting your health information. This makes it very difficult to communicate with a family member or to leave a message on your answering machine. Please indicate below your permission to speak to a family member (specify name), or to leave a message on your answering machine. Please be advised this authorization will **expire one year** from date signed.

I hereby give permission to the Division of Reproductive Genetics to:

A)	Leave a message on my answering machine at (Phone #)	
B)	Leave test results on my answering machine	☐ Yes	□ No
		Phone #	
C)	Give information regarding test results to me and	Name of other person	
S	ignature of Patient	Date Signe	ed